STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295006	A. BUILDING _____ B. WING _____	09/18/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAS VEGAS HEALTHCARE AND REHAB CENTER	2832 S. MARYLAND PARKWAY LAS VEGAS, NV 89109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the annual Medicare re-certification survey conducted at your facility on 9/15/09 through 9/18/09. The census at the time of the survey was 73. The sample size was 15. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following deficiencies were identified:	F 000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F 155 *a) What corrective action's will be accomplished for those residents found to have been affected by the deficient practice:* 1) The Code Status for Resident #1 has been reviewed with the resident and a new DNR form, condition form and care plan have been completed to co-inside with resident wishes and physician order effective 09/24/09. 2) The code status for resident #8 has been clarified with Residents Mother and the DNR form, Condition form and Care plan have been completed to co-inside with these wishes and the physician order. *b) How will you identify other residents having the potential to be affected by the same practice and what anticipated corrective action will be taken:* An Audit of the current facility resident's code status is being conducted to verify that resident wishes	
F 155 SS=D	483.10(b)(4) NOTICE OF RIGHTS AND SERVICES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, the facility failed to ensure an advance directive was formulated for 2 of 15 residents (Resident #1 and #8). Findings include: Resident # 1	F 155		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 11/03/09

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 155	Continued From page 1 Resident #1 was a 73 year old male originally admitted to the facility on 3/9/06, and readmitted on 8/31/07, with diagnoses including Peripheral Vascular Disease, Bilateral Above Knee Amputations, Diabetes and Coronary Artery Disease. Review of the medical record revealed Resident #1 had been on Solari Hospice from 8/21/08 through 9/9/09, at which time he was discharged from the Hospice due to extended prognosis. The Condition Alert Form on the medical record indicated, "Hospice Care" and Code Status "DNR" (Do Not Resuscitate). The code status forms in the medical record dated 9/11/07 and 2/12/09, signed by Resident # 1 indicated, "Yes. I Do Want Resuscitation." Resident # 1's care plan did not address the resident's code status. On 9/17/09, in the afternoon, the Director of Nurses (DON) indicated the resident's correct code status was to resuscitate the resident in an emergency. She indicated the Condition Alert Form, which documented Resident #1 was a DNR, was a mistake. When asked by the surveyor how would the nurses know which form was correct and which emergency measures to take, the DON responded they would disregard the "DNR" form. The DON and the Social Worker (SW) revealed neither of them had discussed Resident #1's code status with him after he was discharged from Hospice.	F 155	have a corresponding Advanced Directive/DNR Physician order, Condition form, and Care Plan . Any inconsistencies will be corrected to reflect Resident wishes. c) *What measures will be put into place or what systemic changes will you make to ensure the deficient practice does not recur:* Staff will be re-educated on our DNR policies and Procedures. Periodic, in-services on these policies will take place during the monthly staff meetings. The Advanced Directives/DNR wishes of the residents will be reviewed during the quarterly resident's care plan meeting and with any identified change of condition. d) *How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:* The Social Service Director or r Designee will conduct random audits to verify that the Code Status is documented per Resident wishes, physician orders and consistent with policy.	

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F 155	Continued From page 2 Resident #8 Resident #8 was a 45 year old male originally admitted 4/10/09, and readmitted 6/12/09, with diagnoses including Encephalopathy, Drug abuse Not Elsewhere Classified in Remission, Bacteremia, Infection Microorganism Resistant Penicillins, Pneumococcus Infection, Urinary Tract Infection, Intestinal Infection E Coli (Escherichia Coli), Persistent Vegetative State, History of Venous Thrombosis/Embolism, Dysphagia, Attention to Gastrostomy, Fitting Urinary Devices, Failure to Thrive - Adult, Protein - Caloric Malnutrition, and Hyperlipidemia. The Advance Directive included in the file (undated) completed by Resident #8's mother marked, "Other. I would like all emergency acts performed such as medication, ambulance to other hospital if need be, or CPR (Cardiopulmonary Resuscitation). However, no severe chest compressions such as might break bones or etc (et cetera)." The Advance Directive included in the file had a check mark next to the sentence, "Yes I do want resuscitation," and handwritten note stating, "Full code, res (resident) is unable to sign. Mailed to his mother on 6-15-09 to sign." (Note: The date indicated on the note was 6/15/09). The Advance Directive included in the file was signed and dated by Resident #8's mother on 6/20/09 and indicated, "Yes, I do want resuscitation. Basic CPR, oxygen, transport to nearest hospital but no harsh beating of the chest where bones may be broken."	F 155	The Interdisciplinary Team will review Code Status during regular Care Plan Meetings with Residents or their Representatives to monitor for correct Status per Wishes. Any non-compliance will be corrected immediately and reported to the performance Improvement committee. *e) Responsible person, designee:* The Executive Director is responsible for accomplishing and/or monitoring compliance. *f) Completion Date:* Date of correction is November 10, 2009.	

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F 155	Continued From page 3 The Advance Directive included in the file with New Hope Hospice's letterhead (not signed nor dated) indicated, "I, (Resident #8)/(Name of Resident #8's mother), have requested in the event of a cardiac or respiratory arrest, no cardiopulmonary resuscitation be undertaken. I consent only to palliative care to maintain comfort." Further handwritten note indicated, "6/19/09 phone consent 3:15 PM." Interview on 9/17/09 in the afternoon, the Social Worker (Employee #3) indicated that after Resident #8 was approved for hospice services, the nurse from New Hope Hospice should have had new paperwork filled out and signed by the resident's mother. The Social Worker indicated she was not sure what the response to the need for resuscitation was requested by the resident's mother. There was no documented evidence contained in the Social Worker's Progress Notes or in the hospice section of the resident's file indicating a clarification of the resident's mother's different requests regarding resuscitation.	F 155	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F 166 *a.) What corrective action's will be accomplished for those residents found to have been affected by the deficient practice:* A grievance form is in place for Resident #16 regarding issues with how she believes she is being treated by staff. As a result, the facility Staff have been in-serviced regarding appropriate interaction with residents.	
F 166 SS=D	483.10(f)(2) GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to follow up and resolve grievances for 1 unsampled resident (#16). Findings include:	F 166	Resident # 16 expresses understanding of the resolution of her grievance and has no present concern about staff interactions at this time, during regular visits by the Social Services. The Social Service Director will continue to visit Resident #16 regularly to verify she continues to have no concerns with treatment by staff *b) How will you identify other residents having the potential to be affected by the same practice and what anticipated corrective action will be taken:*	

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F 166	Continued From page 4 Resident # 16 Resident #16 was a 40 year old female admitted to the facility on 6/2/09, with diagnoses including backache, abdominal pain, hypertension, convulsions, depressive disorder, and lack of coordination. On 9/16/09, during the group meeting, Resident #16 revealed she had filed a grievance with the Social Worker (SW) regarding the inappropriate treatment she was receiving from staff members, especially Employee # 4. Resident #16 revealed staff were making rude remarks and gestures regarding her relationship with another resident of the facility, Resident #17. Resident #16 added she was very hurt and humiliated by the remarks and wanted the issue to be addressed. Resident # 16 became very tearful while describing the incidents, as did Resident #17, who was also present at the group meeting. Resident #16 added she did not feel the issues were addressed and followed up, or resolved. On 9/18/09 at 3:00 PM, the SW revealed Resident #16 had made several complaints to her regarding the treatment she was receiving from staff members. The SW indicated Resident #16 complained that Employee #4 was making gestures to her that Resident #16 found offensive. The SW demonstrated the gesture which was rubbing the thumb and first and second finger, commonly representative of a sign of money. The SW revealed she notified the Administrator	F 166	All residents have the potential to be affected. Through staff visits, as part of the Angel Care program, staff will survey residents and will verify that any grievances are documented, follow-up occurs and that the residents know the resolution per policy. Any non-compliance with policy will be corrected immediately. c) *What measures will be put into place or what systemic changes will you make to ensure the deficient practice does not recur:* All staff will be in-serviced on the grievance policy and the procedure for documenting, investigation and resolution of grievances. d) *How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:* Through staff visits as part of the Angel Care program, and regular Resident Council meetings, the facility will conduct random surveys of Residents regarding grievances. Verification that all grievances are handled per policy will occur., The grievance log will be reviewed daily in Morning meeting by the Executive Director. Any non-compliance will be corrected immediately and reported to the PI committee	

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F 166	Continued From page 5 regarding the complaint and the SW talked to Employee #4. The SW indicated she also talked to other staff who Resident #16 had indicated made rude comments. The SW revealed she did not write down the complaint as a grievance since she talked to the staff members involved and believed the issue was resolved. The facility policy titled, Grievances, dated 11/18/05 revealed: "Documentation Guidelines 1. Document on the Grievance/Complaint Report form the date, resident/family name and issue or concern. 2. Log the complaint/concern on the complaint or grievance log. 3. Document in the resident's medical record if appropriate and on the Grievance/Complaint Report form the notification of resident or family member/responsible party of the resolution of the grievance/concern...." Cross reference with TAG 250	F 166	*e) Responsible person, designee:* The Executive Director is responsible for accomplishing and/or monitoring compliance. *f) Completion Date:* Date of correction is November 10, 2009. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F 167 *a) What corrective action's will be accomplished for those residents found to have been affected by the deficient practice:* The Survey results are posted in the front lobby in a readily available space by the front desk. Resident #10 has been notified of the location. The resident council has been reminded	
F 167 SS=C	483.10(g)(1) EXAMINATION OF SURVEY RESULTS A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.	F 167		

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F 167	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure residents were aware of the location and the availability of the most recent survey conducted by Federal or State Surveyors. Findings include: Resident #10 Resident #10 was a 55 year old male admitted to the facility on 5/6/09, with diagnoses to include Prostate Cancer with resection, Cervical Neuropathy, Cervical Spondylosis with Myelopathy and Hemiplegia due to a motor vehicle accident. During an interview with Resident #10 on 9/16/09, he voiced several complaints and inquired what was being done with these complaints. Resident #10 was asked if he knew that he could read a copy of the facility's Statement of Deficiencies and their Plan of Correction. The resident was unaware of where this information was located. Group Interview During the group interview on 9/16/09, 11 of 11 residents did not know where the survey results were located.	F 167	of the location of the Survey results in a meeting on 10/28/09. b) *How will you identify other residents having the potential to be affected by the same practice and what anticipated corrective action will be taken:* Through the Angel Care program current facility residents will be asked to verify their knowledge of the location of the Survey Results if they are unclear, they will be educated as to the location of the survey results. c) *What measures will be put into place or what systemic changes will you make to ensure the deficient practice does not recur:* The exact location of the Results is being added to the Hospitality Guide which is given to the residents at the time of admission.. The location of the survey Results will also be included in the information periodically regularly reviewed in Monthly Resident Council meetings. d) *How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:* Through the Angel Care program, the	
F 172 SS=C	483.10(j)(1)&(2) ACCESS AND VISITATION RIGHTS The resident has the right and the facility must	F 172		

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F 172	Continued From page 7 provide immediate access to any resident by the following: Any representative of the Secretary; Any representative of the State; The resident's individual physician; The State long term care ombudsman (established under section 307 (a)(12) of the Older Americans Act of 1965); The agency responsible for the protection and advocacy system for developmentally disabled individuals (established under part C of the Developmental Disabilities Assistance and Bill of Rights Act); The agency responsible for the protection and advocacy system for mentally ill individuals (established under the Protection and Advocacy for Mentally Ill Individuals Act); Subject to the resident's right to deny or withdraw consent at any time, immediate family or other relatives of the resident; and Subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, others who are visiting with the consent of the resident. The facility must provide reasonable access to any resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.	F 172	facility will conduct random surveys of Residents Any misconceptions about the availability and location of the results will be corrected immediately and reported to the Performance Improvement committee. *e) Responsible person, designee:* The Executive Director is responsible for accomplishing and/or monitoring compliance. *f) Completion Date:* Date of correction is November 10, 2009 *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F 172 *a) What corrective action's will be accomplished for those residents found to have been affected by the deficient practice:* No specific residents were identified as being affected.	

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F 172	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation and interviews, the facility failed to ensure residents who had immediate family that wished to see residents after 8:00 PM were allowed visitation rights. Findings include: A sign located in the lobby of the facility indicated, visiting hours were until 8:00 PM. During the group meeting on 9/16/09 at 10:00 AM, 10 of 11 residents present indicated they could not visit with relatives or close friends after 8:00 PM. Some residents indicated they had family that worked odd shifts and they would like to make arrangements to visit with them after 8:00 PM. The Administrator indicated on 9/17/09, that he had to restrict the visiting hours because the facility was located in a high crime area.	F 172	The sign in the front lobby has been changed from stating the visiting hours are until 8:00 PM to the following statement: "For the Safety of our Residents, the doors are locked after 8:00 PM. For Visitation after this time, Please contact a Nursing Supervisor @ 735-5848 to make arrangements." This is consistent with the information on our visitation policy provided to residents at the time of admit. A letter will be sent to families notifying them of our visitation policy. b) *How will you identify other residents having the potential to be affected by the same practice and what anticipated corrective action will be taken:* The Executive Director met with the resident council on 10/28/09 to verify that they understood the visitation policy. *What measures will be put into place or what systemic changes will you make to ensure the deficient practice does not recur:* All staff are being were in-serviced on our visitation policy.	
F 226 SS=D	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, the facility failed to develop and implement a policy which prohibits mistreatment, neglect, and abuse.	F 226		

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F 226	Continued From page 9 Findings include: The facility's policy and procedure regarding abuse (dated 4/28/09) states as follows: "...8. The center implements procedures that include: Screening, Training, Prevention, Identification, Investigation, Protection, and Reporting/Response. 9. Investigations into the past histories of a potential employee include: a. Inquiry of the state nurse aide registry or licensing authority; b. Inquiry of previous and/or current employers; and c. Reasonable efforts to uncover information about any past criminal prosecutions...COMPLIANCE GUIDELINES:...6. Each applicant applying for employment provides employment references and authorization to check those references at the time application is made. a. Reference checks may be conducted by telephone or written correspondence. b. Employment is conditional upon successful completion of the reference checks..." Employee #17 was employed as an Occupational Therapist 4/18/06. There was no documented evidence that reference checks were completed for Employee #17. There were 2 sheets included in Employee #17's file with the title, "Reference Checks," which were not filled out. Employee #15 was employed as a Laundry Worker 10/2/01. There was no documented evidence that reference checks were completed for Employee #15. On 9/18/09 in the afternoon, the Administrator indicated both Physical Therapy and the Laundry workers were contracted services and both	F 226	c) *How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:* d) Through our Angel Care program, staff will verify periodically, resident understanding of our visitation policy and if any issues with lack of access to visitors arise, they will be corrected immediately and reported to the Executive Director and the PI Committee. e) *Responsible person, designee:* The Executive Director is responsible for accomplishing and/or monitoring compliance. f) *Completion Date:* Anticipated date of correction is November 10, 2009.	

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F 226	Continued From page 10 services did not require reference checks for their employees. Note: Both the Laundry workers and the Physical Therapy employees have access to resident rooms. The Therapy Department employees have direct care with residents.	F 226	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 241 SS=E	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on interviews, the facility failed to promote care in a manner and in an environment that maintains or enhances each resident's dignity and respect for Residents #10, #13, #16, #17, and group interviewed Residents. Findings include: Resident #10 Resident #10 was a 55 year old male admitted to the facility on 5/6/09, with diagnoses to include Prostate Cancer with resection, Cervical Neuropathy, Cervical Spondylosis with Myelopathy and Hemiplegia due to a motor vehicle accident. 1. On 6/16/09 at 9:00 AM, Resident #10 indicated he would not let the facility wash his clothing any longer because they kept losing his clothing. Resident #10 indicated he had a brand new pair of pants that was sent to the laundry. He	F 241	F 226 *a) What corrective action's will be accomplished for those residents found to have been affected by the deficient practice:* No specific residents were noted to be affected. *b) How will you identify other residents having the potential to be affected by the same practice and what anticipated corrective action will be taken:* The facility is now requiring that these Contractors with employees working in the facility have documented reference checks on those employees in addition to the background checks and drug screenings previously required. *What measures will be put into place or what systemic changes will you make to ensure the deficient practice does not recur:* Contractors will provide evidence the to the facility that any employees hired to work in the facility have had reference	

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F 241	Continued From page 11 indicated the pants were given to his roommate, although he attempted to tell staff they were not his roommate's pants. Resident #10 indicated he told several staff members and staff ignored him. Resident #10 indicated after his roommate worn the pants for several days a staff member realizing they were Resident #10's pants and attempted to give them back to Resident #10. Resident #10 refused the returned pants and indicated he was not going to wear clothing that someone else had been wearing. 2. On 9/16/09, Resident #10 indicated he had had some teeth extracted a few weeks prior. He further indicated he had asked the Dietary Manager to leave him some sherbet in the kitchen for the weekend because his gums were hurting and was unable to chew. The resident indicated the Dietary Manager left Resident #10, six cups of sherbet in the nourishment room with Resident #10's name on the cups. Resident #10 was given 1 cup of sherbet and was told the other 5 cups were given to other residents. He indicated no staff member attempted to give him Herbert or ice cream until the Dietary Manager came back to work. On 9/17/09 in the afternoon, the Dietary Manager indicated she did leave 6 cups of sherbet in the nourishment room for Resident #10 with his name on each cup for the weekend. 3. Resident #10 indicated on 9/16/09 in the morning, he heard staff members speak in a foreign language in the hall. He indicated they yell down the hall to each other at times. He indicated he sometimes felt that they were talking bad about him because he did not understand what they were saying.	F 241	checks completed prior to starting to work in the facility. c) *How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:* The Executive Director or Designee will verify that reference checks are completed on any new employees that contractors have working in the facility. Any New Employees without reference checks will not be allowed to work in the facility until this is completed. *d) Responsible person, designee:* The Executive Director is responsible for accomplishing and/or monitoring compliance. *e) Completion Date:* Anticipated date of correction is November 10, 2009.	

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F 241	Continued From page 12 On 9/16/09 in the morning, while interviewing Resident #10, two housekeepers were overheard speaking a foreign language near Resident #10's room. Group Meeting a. All the residents present at the group meeting complained staff speak in foreign languages while they are assisting the resident with activities of daily living. b. During the group meeting held on 9/16/09 at 10:00 AM, 8 of the 11 residents present indicated they have had laundry missing and were never returned. Three residents indicated they saw their clothing on other residents. The Administrator indicated on 9/17/09, that unclaimed clothing is sometimes given to residents who are admitted to the facility with no clothing. c. All the residents present at the group meeting indicated, laundry staff go into their closets without permission and remove hangers. The residents indicated their families buy the hangers for personal use and do not want them removed. The residents indicated there were two men who continually went into their closets and never returned their hangers. On 9/17/09 in the morning, an interview with the Director of the Contracted Laundry Company used by the facility indicated there are two laundry personnel who do remove hangers from residents closets to hang up their clothing. He	F 241	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F 241 *a) What corrective action's will be accomplished for those residents found to have been affected by the deficient practice:* 1) The grievance concerning Resident #10 and his clothing had been resolved in June 2009 with the facility arranging for re-imbursement of the items. At this time, existing clothing was marked and listed on the inventory sheet. Staff were also in-serviced on identifying the correct clothing belonging to a resident before dressing each resident. 2) Resident #10's issue regarding access to sherbet during the time frame mentioned was resolved at the time of the survey. The sherbet is scheduled and delivered with his meal trays.	

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F 241	Continued From page 13 indicated he had no idea they were removing hangers without permission. d. Eight of 11 residents complained that when the staff came in to assist them with morning care, staff change the television channels without permission. Residents #16 and #17 On 9/16/09 at 10:00 AM, during the group meeting two unsampled residents (#16 and #17) expressed concerns about a relationship they were having since both were admitted to the facility. Resident #16 indicated she overheard several of the Certified Nursing Assistants (CNA) making fun of her relationship with the male resident. Both Resident #17 and #16 were crying while discussing the incident that occurred when the CNAs were making jokes about the resident's relationship. On 9/16/09, Resident #16 indicated to the Administrator that Employee #4 told her she just wanted Resident #17 for his money and made a hand gesture to indicate "Money". She indicated she filed a grievance with the Social Worker. Resident #13 Resident #13 was a 61 year old male admitted to the facility on 7/16/09, with diagnoses including bacteremia, chronic renal failure, dialysis, hypertension, peripheral artery disease and diabetes. a) Observation on 9/17/09 in the afternoon, a nurse administering medications via Resident	F 241	3) Staff has been in-serviced on identifying labeled nourishments and proper delivery to the correct resident. Resident #10 has had no new concerns related to this issue. 4) Resident #10 's concern related to over hearing employees speaking a foreign language in the hall was addressed by re-inservicing the staff on speaking only English to each other in Resident Care areas. Facility management completes random rounds to verify compliance. 5) The residents at the group interview were not identified in the statement of Deficiencies in order to specify a specific correction for them. 6) Resident #16 and #17 a grievance has from has been completed related to their concerns around staff treatment regarding their relationship. The issue has been investigated and Staff has been in-serviced on not discussing resident's personal relationships, and on Professional boundaries. No new concerns on staff treatment and Executive Director is verifying this .during regular rounds. 7) Resident #13 has been discharged prior to receiving the statement of	

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F 241	Continued From page 14 #13's Gastrostomy tube (G-tube). The nurse pulled the curtain so Resident #13 was not visible from the hallway. The nurse partially pulled the curtain that separated the A & B beds within the room. Resident #13's roommate was sitting in the wheelchair at the foot of his bed and could see Resident #13. The nurse pulled down Resident #13's sheet exposing his abdomen and G-Tube. The nurse began administering the medications. While the nurse was administering the medications, Resident #13's roommate asked the surveyor to please pull the curtain so Resident #13 would not be visible to him. The surveyor held the curtain closed until Resident #13's G-tube medications were administered. b) On 9/18/09 during the family interview, Resident #13's POA (Power of Attorney) indicated Resident #13 was not groomed properly. He indicated Resident #13's nails were very long and dirty. The POA revealed he had asked staff on several occasions to trim Resident #13's nails and that had not been done. On 9/18/09 in the afternoon, Resident #13's nails were observed to be very long with dirt underneath the nails.	F 241	deficiencies. b) *How will you identify other residents having the potential to be affected by the same practice and what anticipated corrective action will be taken:* All Residents have the potential to be affected. Regular rounds will be conducted by the Executive Director along with feedback from residents during resident council and Angel Care visits to determine if any dignity issues exist. Rounds and interviews will focus on any issues around privacy being protected during care, treatments or medication, administration, missing clothing, Requested food not being delivered timely, staff Speaking only English in patient care areas, staff removing hangers or other items from a residents' room without permission, and changing resident televisions without permission. All staff including Licensed staff will be in-serviced on the facilities Quality of Life Policy in regards to Dignity/Privacy issues. *c)What measures will be put into place or what systemic changes will you make to ensure the deficient practice does not recur:*	
F 246 SS=E	483.15(e)(1) ACCOMMODATION OF NEEDS A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.	F 246		

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F 246	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation and interviews, the facility failed to ensure the residents had an area where they could go outdoors to accommodate the non-smokers and residents on oxygen therapy. Findings include: During the group meeting on 9/16/09, 11 of 11 residents present complained that the patio outside the dining room was not accessible to them. Several residents present at the meeting were non-smokers. Three residents used oxygen. The residents indicated they wanted to go somewhere outdoors that was smoke-free. The residents who were oxygen dependent were afraid to be near smokers. Observation of the patio located outside of the dining room on 9/16/09, revealed the area was cluttered with rehabilitation equipment. On 9/16/09, the Administrator indicated he was aware the area needed to be cleaned up for resident use who are non-smokers and oxygen dependent.	F 246	In addition to the above mentioned In-service, facility staff training is being conducted related to the following: Appropriate interactions with Residents including Professional boundaries, not changing Resident television channels without permission. Speak to the residents only in English. English- only Communication is to take place in the Resident Care Areas Review of the policy and procedures related to protection of resident property including hangers and clothing. In-services for Nursing staff will also include the following: Proper grooming of residents , including attention to care of the resident's nails Their responsibility to provide privacy and dignity during personal care. How to correctly distribute resident nourishments. Additional in-services will be provided to the Licensed Nursing Staff on the following:	
F 250 SS=D	483.15(g)(1) SOCIAL SERVICES The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 250		

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F 250	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure appropriate medically related social services to maintain physical and psychological well being for 1 of 15 sampled residents (#1) and 1 unsampled resident (#16). Findings include: Resident #1 Resident #1 was a 73 year old male originally admitted to the facility on 3/9/06, and readmitted on 8/31/07, with diagnoses including Peripheral Vascular Disease, Bilateral Above Knee Amputations, Diabetes and Coronary Artery Disease. Review of the medical record revealed Resident #1 had been on Solari Hospice from 8/21/08 through 9/9/09, at which time he was discharged from the Hospice due to extended prognosis. The Condition Alert Form on the medical record indicated, "Hospice Care" and Code Status "DNR" (Do Not Resuscitate). The code status forms in the medical record dated 9/11/07 and 2/12/09, signed by Resident # 1 indicated, "Yes. I Do Want Resuscitation." Resident # 1's care plan did not address the resident's code status. On 9/17/09, in the afternoon, the Director of Nurses (DON) indicated the resident's correct code status was to resuscitate the resident in an	F 250	Their responsibility to protect the resident's privacy and dignity during medication and treatment administration. *d) How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:* Regular walking rounds will continue to be conducted by the Executive Director, along with Resident feedback during Angel Care Visits to determine any noncompliance with the regulation or our policies concerning Dignity. Any Noncompliance will be corrected immediately and results reported to the PI Committee. *e) Responsible person, designee:* The Executive Director is responsible for accomplishing and/or monitoring compliance. *f) Completion Date:* Anticipated date of correction is November 10, 2009.	

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F 250	Continued From page 17 emergency. She indicated the Condition Alert Form, which documented Resident #1 was a DNR, was a mistake. When asked by the surveyor how would the nurses know which form was correct and which emergency measures to take, the DON responded they would disregard the "DNR" form. The DON and the Social Worker (SW) revealed neither of them had discussed Resident #1's code status with him after he was discharged from Hospice. Resident #16 Resident #16 was a 40 year old female admitted to the facility on 6/2/09, with diagnoses including Backache, Abdominal pain, Hypertension, Convulsions, Depressive Disorder, and lack of coordination. On 9/16/09 during the group meeting, Resident #16 revealed she had filed a grievance with the Social Worker (SW) regarding the inappropriate treatment she was receiving from staff members, especially Employee #4. Resident #16 revealed staff were making rude remarks and gestures regarding her relationship with another resident of the facility, Resident #17. Resident #16 added she was very hurt and humiliated by the remarks and wanted the issue to be addressed. Resident #16 became very tearful while describing the incidents, as did Resident #17, who was also present at the group meeting. Resident #16 added she did not feel the issues	F 250	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F 246 a) *What corrective action's will be accomplished for those residents found to have been affected by the deficient practice:* No specific residents were identified. b) *How will you identify other residents having the potential to be affected by the same practice and what anticipated corrective action will be taken:* All residents have potential to be affected. Facility staff is in the process of clearing the patio off of the dining room of all items being stored there. The patio will be available for Resident use by 11/10/09. c) *What measures will be put into place or what systemic changes will you make to ensure the deficient practice does not recur:* Staff has been instructed to keep the patio off of the dining room for resident use. A sign will designate this as a non-smoking resident area.	

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F 250	Continued From page 18 were addressed and followed up. On 9/18/09 at 3:00 PM, the SW revealed Resident #16 had made several complaints to her regarding the treatment she was receiving from staff members. The SW indicated Resident #16 complained that Employee #4 was making gestures to her that Resident #16 found offensive. The SW demonstrated the gesture which was rubbing the thumb and first and second finger together, commonly representative of a sign of money. The SW indicated she notified the Administrator regarding the complaint and the SW talked to Employee #4. The SW indicated she also talked to other staff who Resident #16 had indicated made rude comments. The SW did not write down the complaint as a grievance since she talked to the staff members involved and believed the issue was resolved. The facility policy titled, Grievance, dated 11/18/05 revealed the following: Primary Responsibility Social Service Director/Designee " Record the date, resident/family name, and issues or concern on the center grievance log." " Notify the resident to family member/responsible party of the resolution. Respond to the resident and family member/responsible party within three days, even if the issue is not completely resolved, " Record the date resolved on the center Grievance Performance Improvement Log."	F 250	d) *How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:* The Maintenance Director will make regular rounds checking that the Patio is clear of any objects for storage and is safe for resident use. Any non-compliance will be corrected immediately and reported to the Executive Director and the Performance Improvement committee. e) *Responsible person, designee:* The Executive Director is responsible for accomplishing and/or monitoring compliance. f) *Completion Date:* Date of correction is November 10, 2009. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F250	

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F 250	Continued From page 19 Cross reference to TAG 166	F 250		
F 252 SS=E	483.15(h)(1) ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the environment was safe, clean comfortable, and homelike. Findings include: 1. On 9/15/09, 9/16/09, 9/17/09, and 9/18/09, there were foul urine and fecal odors present at the front lobby and throughout the 100 Hall. 2. On 9/15/09 upon entry to the facility at 8:00 AM until approximately 12:00 PM, the handicapped access buttons for the exterior and interior of the front entrance door did not activate the opening of the door. On 9/17/09 upon entry to the facility at 8:00 AM until approximately 10:30 AM, the handicapped access buttons for the exterior and interior of the front entrance door did not activate the opening of the door. Interview with the Administrator on the morning of 9/15/09, it was verified that the access buttons for the front entrance door have been broken and disabled on a regular basis several times throughout each month.	F 252	a) *What corrective action's will be accomplished for those residents found to have been affected by the deficient practice:* 1) The Code Status for Resident #1 has been reviewed with the resident and a new DNR form, condition form and care plan have been completed to co-inside with resident wishes and physician order effective 09/24/09. 2) The code status for resident #8 has been clarified with Resident's Mother and the DNR form, Condition form and Care plan have been completed to co-inside with these wishes and the physician order. b) *How will you identify other residents having the potential to be affected by the same practice and what anticipated corrective action will be taken:* An Audit of the current facility resident's code status is being conducted to verify that resident wishes have a corresponding Advanced Directive/DNR Physician order, Condition form, and Care Plan . Any inconsistencies will be corrected to reflect Resident wishes.	
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS	F 279		

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F 279	Continued From page 20 A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure an accurate care plan was implemented and followed to meet the resident's medical, nursing, mental and psychosocial needs for 1 of 15 sampled residents (#1) and 1 unsampled resident (#18). Findings include: Resident #1 Resident #1 was a 73 year old male originally admitted to the facility on 3/9/06, and readmitted on 8/31/07, with diagnoses including Peripheral	F 279	c) *What measures will be put into place or what systemic changes will you make to ensure the deficient practice does not recur:* Staff will be re-educated on our DNR policies and Procedures. Periodic in-services on these policies will be completed during the monthly staff meetings. The Advanced Directives/DNR wishes of the residents will be reviewed during the quarterly resident's care plan meeting and with any identified change of condition. d) *How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:* The Social Service Director or Designee will conduct random audits to verify that the Code Status is documented per Resident wishes, physician orders and consistent with policy. The Interdisciplinary Team will review Code Status during regular Care Plan Meetings with Residents or their Representatives to monitor for correct Status per Wishes. Any non-compliance will be corrected immediately and reported to the	

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LAS VEGAS HEALTHCARE AND REHAB CENTER	2832 S. MARYLAND PARKWAY LAS VEGAS, NV 89109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY	(X5) COMPLETION DATE
F 250	Continued From page 19	F 250	F 252	
F 252 SS=E	Cross reference to TAG 166 483.15(h)(1) ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the environment was safe, clean comfortable, and homelike. Findings include: 1. On 9/15/09, 9/16/09, 9/17/09, and 9/18/09, there were foul urine and fecal odors present at the front lobby and throughout the 100 Hall. 2. On 9/15/09 upon entry to the facility at 8:00 AM until approximately 12:00 PM, the handicapped access buttons for the exterior and interior of the front entrance door did not activate the opening of the door. On 9/17/09 upon entry to the facility at 8:00 AM until approximately 10:30 AM, the handicapped access buttons for the exterior and interior of the front entrance door did not activate the opening of the door. Interview with the Administrator on the morning of 9/15/09, it was verified that the access buttons for the front entrance door have been broken and disabled on a regular basis several times throughout each month.	F 252	*a) What corrective action's will be accomplished for those residents found to have been affected by the deficient practice:* No specific residents were identified. *b) How will you identify other residents having the potential to be affected by the same practice and what anticipated corrective action will be taken:* All residents have potential to be affected. The Housekeeping Supervisor is scheduling regular rounds throughout the day to verify that the facility is cleaned per standards and that it is free from odors. The Handicapped access button on the front door were repaired on 09/18/09 *c) What measures will be put into place or what systemic changes will you make to ensure the deficient practice does not recur:* All staff is being in-serviced on identifying any barriers to a safe, clean, comfortable and homelike environment. This includes odors and any malfunctioning doors. The training includes reporting the issues to the appropriate discipline for correction.	
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS	F 279		

POC Response to F252

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F 279	Continued From page 20	F 279		

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure an accurate care plan was implemented and followed to meet the resident's medical, nursing, mental and psychosocial needs for 1 of 15 sampled residents (#1) and 1 unsampled resident (#18).

Findings include:

Resident #1

Resident #1 was a 73 year old male originally admitted to the facility on 3/9/06, and readmitted on 8/31/07, with diagnoses including Peripheral

d) *How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:*

The Maintenance Director will make regular rounds and include verification that the handicapped access buttons are functional. Any non-compliance will be corrected immediately and reported to the Executive Director and the Safety Improvement committee.

The Housekeeping Supervisor will complete walking rounds of the facility though-out the day identifying any cleanliness issues including odors, will take action to correct these issues at the source and will report to the Executive Director the issues.

e) *Responsible person, designee:*

The Executive Director is ultimately responsible for accomplishing and/or monitoring compliance.

f) *Completion Date:*

Date of correction is November 10, 2009.

JIM GIBBONS
Governor

MICHAEL J. WILLDEN
Director

RICHARD WHITLEY, MS
Administrator

TRACEY D. GREEN, MD
State Health Officer

STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH DIVISION
BUREAU OF HEALTH CARE QUALITY AND COMPLIANCE

☐ Health Facilities/Lab Services
1550 E. College Parkway
Suite 158
Carson City, Nevada 89706
(775) 687-4475
Fax: (775) 687-6588

☐ Health Facilities/Lab Services
4220 S. Maryland Parkway
Suite 810, Building D
Las Vegas, NV 89119
(702) 486-6515
Fax: (702) 486-6520

☐ Radiological Health
4150 Technology Way
Suite 300
Carson City, Nevada 89706
(775) 687-7550
Fax: (775) 687-7552

☐ Radiological Health
2080 E. Flamingo
Suite 319
Las Vegas, Nevada 89119
(702).486-5280
Fax: (702) 486-5024

Verification of Hand Delivery From Facility

The undersigned, and employee of the Bureau of Health Care Quality and Compliance, did receive the following document(s):

Name of Facility: Las Vegas Healthcare & Rehab

Document(s): Tag Z52 Response for 9/18/09 Recertificat,

on the date below:

Delivered by: Randy Fuller

Date: 1/7/09 **Time:** 10:10 AM.

Received by: S. Coleman

Date: 1/7/09 **Time:** 10:10 Am

I:\forms\Verification of Hand Delivery From Facility.doc

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 279	Continued From page 21 Vascular disease, Bilateral Above Knee Amputations, Diabetes and Coronary Artery Disease. Review of the medical record revealed Resident #1 had been on Solari Hospice from 8/21/08 through 9/9/09, at which time he was discharged from the Hospice due to extended prognosis. The Condition Alert Form on the medical record indicated, "Hospice Care" and Code Status "DNR" (Do Not Resuscitate). The code status forms in the medical record dated 9/11/07 and 2/12/09, signed by Resident # 1 indicated, "Yes. I Do Want Resuscitation." Resident # 1's care plan did not address the resident's code status. Resident #18 Resident #18 was an 81 year old female admitted to the facility on 9/6/09, with diagnoses including back pain, diabetes, coronary artery disease, fall, and acute fracture. Review of Resident #18's medical record following medication pass, revealed Resident #18 had orders for stool for C-diff (Clostridium Difficile) x2. Resident #18's care plan dated 9/11/09 indicated, "...Contact precautions." On 9/16/09 at 8:00 AM, during the medication pass, and throughout the survey, there was no indication Resident #18 was maintained on Contact Precautions.	F 279	performance Improvement committee. *e) Responsible person, designee:* The Executive Director is responsible for accomplishing and/or monitoring compliance. *f) Completion Date:* Date of correction is November 10, 2009. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F279 *a) What corrective action's will be accomplished for those residents found to have been affected by the deficient practice:* 1) The care plan for resident #1 was updated on 09/24//09 to reflect the residents wishes and physician order DNR. This will be reviewed at least quarter to verify that we continue to follow resident wishes.	

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F 279	Continued From page 22 There was no documented evidence in the nurse's notes that Resident #18 was maintained on Contact Precautions. There was no physician order to discontinue the Contact Precautions.	F 279	2) Resident #18 has had isolation precautions discontinued per physician order on 09/19/09. The results were received on 09/12/09 showing that both the C-Diff cultures were negative. *b) How will you identify other residents having the potential to be affected by the same practice and what anticipated corrective action will be taken:* All residents have potential to be affected. 1) Director of Social Services will complete an audit of all residents to verify that DNR status are care planned appropriately. Any issues will be corrected immediately. 2) Nursing Administration reviews change of condition daily Any residents with signs/symptoms of C-diff, or other infectious diseases will be audited to verify that care plans reflect appropriate interventions ,including isolation precautions. *c) What measures will be put into place or what systemic changes will you make to ensure the deficient practice does not recur:* 1)All staff including social services have been in-serviced on the policy and procedures related to DNR orders including the Care Plan process.	
F 318 SS=D	483.25(e)(2) RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide treatment and services for 2 residents with contractures (Resident #8 and #10). Findings include: Resident #8 Resident #8 was a 45 year old male originally admitted 4/10/09, and readmitted 6/12/09, with diagnoses including Encephalopathy, Drug abuse Not Elsewhere Classified in Remission, Bacteremia, Infection Microorganism Resistant Penicillins, Pneumococcus Infection, Urinary Tract Infection, Intestinal Infection E Coli (Escherichia Coli), Persistent Vegetative State, History of Venous Thrombosis/Embolism, Dysphagia, Attention to Gastrostomy, Fitting Urinary Devices, Failure to Thrive - Adult,	F 318		

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F 318	Continued From page 23 Protein - Caloric Malnutrition, and Hyperlipidemia. On 9/15/09, 9/16/09, 9/17/09, and 9/18/09, Resident #8 was observed with bilateral contractures of the hands. All fingers were severely contracted, and the thumbs were pressing against the fingers. On 9/18/09 at 3:30 PM, while Employee #21 attempted to perform passive range of motion and determine whether the pressure of the fingers and thumbs were resulting in skin deterioration, Resident #8 responded in apparent pain. Upon interview regarding whether the resident was evaluated for Physical Therapy services, Employee #21 indicated there was only an initial evaluation by the Physical Therapy Department 6/13/09. Employee #21 further indicated there was no intervention other than passive range of motion for the contractures due to lack of further assessment by the Physical Therapy Department and due to the fact that the resident was receiving hospice services. Based on interview with the Physical Therapy Supervisor (Employee #22) at approximately 4:00 PM on 9/18/09, Employee #22 indicated that the reason there was no further assessment or action regarding Resident #8's contractures was because Resident #8 was on hospice. The Rehab (Rehabilitation) Services Functional Screening Tool dated 6/13/09 stated: "Reason for Screen: Admission". The Range of Motion limitations indicated only moderate and severe range of motion limitations on the bilateral lower extremities, and did not indicate any range of motion limitations on the upper extremities. There was no documented evidence of a plan in	F 318	2)Licensed staff will be in-serviced on the policy and procedures for Care Planning in regards to Isolation precautions, and on our policies related to Clostridium Difficile (C-Diff). d) *How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:* The Social Service Director will continue to audit all residents charts to verify that DNR status are Care Planned per policy. This will also be reviewed at least quarterly during the Care Conferences for each resident. Any discrepancies between the care plan and resident wishes, will be corrected immediately and reported to the Executive Director and Reported to the PI Committee. 2) In addition to the Change of Condition audits, Physician orders will be monitored on a daily basis by Nursing Administration for orders pertaining to C-Diff. It will be verified that Care Plans are in place to reflect the appropriate interventions including isolation per policy and standards of care. Any issues with compliance with Care planning related to C-Diff will be corrected immediately and reported to the Executive Director and the Performance Improvement committee.	

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F 318	Continued From page 24 place to prevent further development of the contractures and to ensure that Resident #8's fingernails were not pressed against the hands. Resident #10 Resident #10 was a 55 year old male admitted to the facility on 5/6/09, with diagnoses to include Prostate Cancer with resection, Cervical Neuropathy, Cervical Spondylosis with Myelopathy and Hemiplegia due to a motor vehicle accident. On 9/16/09 in the morning, Resident #10 was observed moving the fingers of his right hand back and forth and up and down (affected side with hemiparesis). The resident indicated he was doing this because his hand had previously had a spastically opened hand due to his condition. Resident #10 indicated his right hand was starting to contract and he wanted to strengthen it. Resident #10 indicated he could use a soft exercise ball to strengthen his hand. On 9/16/09, the Director of therapy indicated he had thought that Resident #10 had an exercise ball and he would look into getting him another one.	F 318	*b) Responsible person, designee:* The Executive Director is responsible for accomplishing and/or monitoring compliance. *c) Completion Date:* Date of correction is November 10, 2009. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law* F318 *a) What corrective action's will be accomplished for those residents found to have been affected by the deficient practice:* 1)Resident #8 was evaluated on 09/21/09 by Occupational Therapy and placed on therapy for splinting to bilateral upper extremities. 2) Resident #10 was evaluated on 09/16/09 by Occupational Therapy and splint wearing schedule was implemented for Right upper extremity. *b) How will you identify other residents having the potential to be affected by the same practice and what anticipated corrective action will be taken:*	
F 442 SS=D	483.65(b)(1) PREVENTING SPREAD OF INFECTION When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. This REQUIREMENT is not met as evidenced	F 442		

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F 442	Continued From page 25 by: Based on observation, interview and record review, the facility failed to ensure a resident was maintained in isolation to prevent the spread of infection (Unsampled Resident #18). Findings include: Resident #18 was an 81 year old female admitted to the facility on 9/6/09, with diagnoses including back pain, Diabetes, Coronary Artery Disease, fall, and acute fracture. Review of Resident #18's medical record following medication pass, revealed Resident #18 had orders for stool for C-diff (Clostridium Difficile) x2. Resident #18's care plan dated 9/11/09 indicated, "...Contact precautions." On 9/16/09 at 8:00 AM, during the medication pass, and throughout the survey, there was no indication Resident #18 was maintained on Contact Precautions. There was no documented evidence in the nurse's notes that Resident #18 was maintained on Contact Precautions. There was no physician order to discontinue the Contact Precautions. On 9/17/09 in the afternoon, the Director of Nurses (DON) indicated Contact Precautions were initiated when a resident was suspected of having C-Diff, not when the results of the specimen were received. The DON added she was not sure if Resident #18 was on Contact Precaution but they have been discontinued.	F 442	All residents have potential to be affected. The Rehabilitation Coordinator and Nursing Management will complete regular resident rounds to verify that any resident with or those with potential for contractures have been addressed. c) *What measures will be put into place or what systemic changes will you make to ensure the deficient practice does not recur:* The Rehabilitation Manager will in-service Therapy staff on identifying residents that can benefit from Contracture prevention or management programs. The above noted screenings will be regularly completed on all residents. In addition Change of conditions will be reviewed daily and any decline in function/use of extremities will be referred to Therapy for Screenings to determine need for interventions. d) *How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:* The Rehabilitation Coordinator and Nursing Management will continue to complete regular resident rounds to verify that any resident with or those	

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F 442	Continued From page 26 The facility policy titled, Isolation Precautions, dated 10/31/06 revealed: -"...Maintain isolation precautions until discontinued by the attending physician." - "Documentation Guidelines 1. Document in the medical record and update care plan as needed for: - a. Reason for isolation; - b. Type of isolation; 1) Contact 2) Droplet 3. Airborne - c. Duration of isolation; - d. Physician's orders; - e. Notification of family/responsible party; and - f. Discontinuation of isolation..."	F 442	with potential for contractures have been addressed. Any non-compliance will be corrected immediately and reported to the Director of Nursing and the Performance Improvement committee. *e) Responsible person, designee:* The Director of Nursing Servicing is responsible for accomplishing and/or monitoring compliance. *f) Completion Date:* Date of correction is November 10, 2009. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law* F442 *a) What corrective action's will be accomplished for those residents found to have been affected by the deficient practice:* Resident #18 had isolation precautions discontinued per physician order on 09/19/09.	

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LAS VEGAS HEALTHCARE AND REHAB CENTER

SMOKING POLICY FOR RESIDENTS, STAFF AND VISITORS

Smoking of tobacco products is an individual choice but due to the hazards of the combustible materials associated with smoking the following policies are in effect within the confines of the property associated with Las Vegas Healthcare and Rehab Center.

1. Smoking will be limited to all persons to outside the physical structure of Las Vegas Healthcare and Rehab Center. No smoking signs are also posted outside the front entrance way asking that no smoking occurs in that area either.

2. There is one area in which smoking is allowed for visitors and residents. The area is the East courtyard. Appropriate containers such as ashtrays and butt cans are provided in those areas. An additional designated smoking area for staff members is the patio area on the Northeast side of the property.

3. Residents of Las Vegas Healthcare and Rehab may not possess smoking materials such as tobacco products, lighters and matches. These materials will be kept at the appropriate nurses' station for residents that smoke. The only exception to this rule will be residents who have requested to retain their own smoking materials and via care plan conference the Interdisciplinary Care Team has approved the retention of smoking materials.

4. Residents who are capable of handling their own smoking materials and residents who are capable of retaining their own smoking materials per the IDT and Care Plan Process will not be subject to smoking times. They may utilize their tobacco products at their leisure providing no other persons are subjected to any unsafe condition due to the combustible materials.

5. Residents who are not able to retain their smoking materials or are not able to smoke at their leisure due to safety concerns will be allowed to smoke in a supervised environment at designated smoking times. The facility designates 9:30 a.m., 11:30 a.m., 2 p.m., 4 p.m. and 7 p.m. as designated smoking times. The facility will provide a staff member during those times to supervise smoking activities for those residents who need it. These times will be adhered to as closely as possible and are subject to change depending upon availability of staff members.

_____ _____

Signature of resident/Signature of Legal Representative Date

_____ _____

Signature of Facility's Authorized Agent Date

EXHIBIT A

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F 442	Continued From page 26 The facility policy titled, Isolation Precautions, dated 10/31/06 revealed: -"...Maintain isolation precautions until discontinued by the attending physician." - "Documentation Guidelines 1. Document in the medical record and update care plan as needed for: - a. Reason for isolation; - b. Type of isolation; 1) Contact 2) Droplet 3. Airborne - c. Duration of isolation; - d. Physician's orders; - e. Notification of family/responsible party; and - f. Discontinuation of isolation..."	F 442	policy and procedures for Isolation precautions to include the appropriate documentation as well as the need to obtain a physician order to discontinue isolation. Additional training will be provided on the policies related to Clostridium Difficile (C-Diff). d) *How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:* In addition to the Change of Condition audits, Physician orders will be monitored on a daily basis by Nursing Administration for orders pertaining to C-Diff. It will be verified that appropriate interventions are in place, including isolation per policy and standards of care. Any issues with compliance with policies related to C-Diff will be corrected immediately and reported to the Executive Director and the Performance Improvement committee. *e) Responsible person, designee:* The Executive Director is responsible for accomplishing and/or monitoring compliance. f) *Completion Date:* Date of correction is November 10, 2009.	